STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 87 30562

0689644 OCT 20 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1 DECEASED NAME (TYPE OR PRINT) FIRST: Eleanor	MIDDLE: N.	LAST: Acri	2a DATE OF DEATH MONTH DAY YEAR: October 15 1987	2b HOUR: 6 19 PM	
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH MONTH DAY YEAR: 03 16 10	6 AGE (IN YEARS LAST BIRTHDAY): 77 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD		
10 CITY OR TOWN OF DEATH: Easton	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS
Maryland	Talbot	Oxford	YES ☒ NO ☐	807 S. Morris Street 21654

14 FATHER'S NAME FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Milton		Norris	Helen	Louise	Sadtler

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
no		219-36-5918	Helen Cooper	Rt 1 Box 757 Chestertown MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Pancreatic Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19__ to 10-15, 1987 that (I) (this hospital) last saw the deceased alive on 10-14, 1987, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE		22c DATE SIGNED
Thomas W. Fauntleroy, Jr.	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/16/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
Thomas W. Fauntleroy, Jr. M.D.	403 Marvel Court Easton MD 21601

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10/19/87	Oxford Cemetery	Oxford / Talbot / MD

24 FUNERAL DIRECTOR NAME	ADDRESS	25a DATE RECEIVED BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, MD	OCT 19 1987	Gina Davidson-Landers

0694 02 OCT 23 87 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO B7 30553

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail or transmit pages 1 and 2 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP_____

DHMH 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ANNA — MIDDLE: A. — LAST: ADAMS			2a. DATE OF DEATH — MONTH: 10 — DAY: 10 — YEAR: 87	2b. HOUR: 2:05 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: MONTH 7 — DAY 9 — YEAR 1924	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS	IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): EASTON MEMORIAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Factory	12b. KIND OF BUSINESS OR INDUSTRY: Frozen Food 21632
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) — 13a. STATE: Maryland	13b. COUNTY: Caroline	13c. CITY OR TOWN: Federalsburg	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: Rt. #2 Box 180 Fed., Md.
14. FATHER'S NAME — FIRST: Benjamin — MIDDLE: — LAST: Potts		15. MOTHER'S MAIDEN NAME — FIRST: Catherine — MIDDLE: — LAST: Andersen 21632		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-28-8438	17. INFORMANT — ADDRESS: Roland Adams Rt #2 Box 180 Fed., Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart failure	9-20-87
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Heart disease	Uncertain
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-20, 19 87, to 10-10, 19 87, that (I) (we) last saw the deceased alive on 10-10, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	Robert W. Trever, M.D.	22c. DATE SIGNED: 10-10-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS: RD 3 Box 256 Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10-14-87	23c. NAME OF CEMETERY OR CREMATORY: Bloomery Cemetery	23d. LOCATION — CITY OR TOWN: Fed. — COUNTY: Caroline — STATE: Md.	
24. FUNERAL DIRECTOR — NAME: Harvey Williams — ADDRESS: Federalsburg, Md.		25a. DATE REC'D. BY REGISTRAR: OCT 1 6 1987	25b. REGISTRAR'S SIGNATURE: [illegible]	

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068394 OCT 14 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 30504

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified or called.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary MIDDLE: LAST: Adams		2a. DATE OF DEATH MONTH DAY YEAR: OCT 3, 1987	2b. HOUR: 3 30 P.M.
3. SEX: Female	4. RACE: BLK	5. DATE OF BIRTH MONTH DAY YEAR: 09 01 1885	6. AGE (IN YEARS LAST BIRTHDAY): 102 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Talbot	13c. CITY OR TOWN: St. Michels	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 240 North St. 21663			
14. FATHER'S NAME FIRST: ? MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST: P MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Rev. Andrew Thurman

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 9/3, 19 87 to 10/3, 19 87 that I (we) last saw the deceased alive on 10/2, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ludwig J. Eglseder III MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ludwig J. Eglseder III MD	22e. ADDRESS: RT 3 Box 106 Easton Md 21601		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/8/87	23c. NAME OF CEMETERY OR CREMATORY: Richardson Cemetery	23d. LOCATION CITY OR TOWN: Easton	COUNTY: TA STATE: MD
24. FUNERAL DIRECTOR NAME AND ADDRESS: George Dashiell Funeral Home Easton, Md.		25a. DATE REC'D BY REGISTRAR: OCT 12 1987	25b. REGISTRAR'S SIGNATURE: Julia Tilghman Ludwick	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 30559

1. DECEASED NAME (TYPE OR PRINT) — FIRST: GILBERT | MIDDLE: H. | LAST: APPLER
2a. DATE OF DEATH (MONTH DAY YEAR): 10-14-87
2b. HOUR: 452P M
3. SEX: Male
4. RACE: Cauc.
5. DATE OF BIRTH (MONTH DAY YEAR): Sept. 27, 1910
6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.
10. CITY OR TOWN OF DEATH: EASTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. V.P.
12b. KIND OF BUSINESS OR INDUSTRY: Storage

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Talbot
13c. CITY OR TOWN: Easton
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: Rt #5. Bpx 655. Easton, MD 21601

14. FATHER'S NAME — FIRST / MIDDLE / LAST: Brooke Hopewell Appler
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST: Carrie Edna McCrea
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES): -----
16b. SOCIAL SECURITY NO.: 215-14-4875
17. INFORMANT — ADDRESS: Mina F. Appler Rt. 5, Box 655 Easton, MD. 21601

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <1 Hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Acute coronary thrombosis
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart disease — Uncertain

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: None

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-5 19 80 to 10-14 19 87, that (I) (we) last saw the deceased alive on 10-14 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE — DEGREE: Robert W. Trever, M.D. — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 10-15-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT W. TREVER, M. D.
22e. ADDRESS: RD 3 Box 297 Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct 17, 1987
23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park
23d. LOCATION — CITY OR TOWN / COUNTY / STATE: Baltimore, Maryland
24. FUNERAL DIRECTOR — NAME / ADDRESS: Hanson L. Leonard St. Michaels
25a. DATE REC'D BY REGISTRAR: OCT 19 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pondexa

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (a), (b), or (c), the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

068933 OCT 19 87

Items 18a thru 22a Film G634 12/7/87 jab per Med. Exam.

30566

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG NO

reissued 6 copies mailed 12/7/87 mlg

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary; MIDDLE Dorothy; LAST Ball

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 10 DAY 12 YEAR 87

2b. HOUR: M

3. SEX: FEmale

4. RACE: White

5. DATE OF BIRTH: MONTH 10 DAY 23 YEAR 13

6. AGE (IN YEARS) LAST BIRTHDAY: 73 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 12 YEAR 87

2d. HOUR: 2:04 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot County MD

10. CITY OR TOWN OF DEATH: Easton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Overpass of MD RT 322 & Paper Mill Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Talbot

13c. CITY OR TOWN: Neavitt

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: Manor Road 21652

14. FATHER'S NAME: FIRST William; MIDDLE H.; LAST Brandow

15. MOTHER'S MAIDEN NAME: FIRST Ada; MIDDLE May; LAST Jackson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-26-1890

17. INFORMANT ADDRESS: D. James Ball, Jr. P O Box 402 Neavitt MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Drowning

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a: Alzheimer's Disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH 10 DAY 12 YEAR 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject drowned

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Culvert/draining Ditch

21f. LOCATION STREET Overpass, Md. CITY OR TOWN Rte 322 & Paper Mill COUNTY Easton, Talbot County, Md. STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 10-13-87

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 10/15/87

23c. NAME OF CEMETERY OR CREMATORY: Neavitt Cemetery

23d. LOCATION CITY OR TOWN: Neavitt COUNTY: Talbot STATE: MD

24. FUNERAL DIRECTOR NAME: Newnam Funeral Home ADDRESS: Easton, Maryland

25a. DATE REC'D BY REGISTRAR: OCT 16 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson Landers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PERTINENT ITEMS. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ACCOMPANIED WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP 820

DHMH - 17 (VR A15 ME (5))

068456 OCT 14 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30557

REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYS. "1AN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remove coroner papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
WILLIAM	B.	BERGEN	October	9,	1987	4:00 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	03	29	15	72 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	U.S.A.		Talbot MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
St Michaels	Beverly Road	Executive	Aerospace

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Talbot	St Michaels	YES [ ] NO [X]	Beverly Road 21663

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Oldfield		Bergen	Hazel		Zerniko

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	219-01-3954	Eleanor M. Bergen	P O Box 747 St Michaels MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of The esophagus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3mos

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) this hospital attended the deceased from 9/12 19 87 to 10/9 19 87, that (I) (we) last saw the deceased alive on 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
William J. Banfield	MD		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William J. Banfield, M.D.	505 Dutchman's Lane Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	10/12/87	Woodlawn Memorial Pk	Easton	Talbot	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	OCT 13 1987	Julia Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

069878 OCT 27 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 87-3068

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered by the local registrar or deputy, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must complete page 4.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LAWRENCE	MIDDLE: E.	LAST: BIRGE	2a. DATE OF DEATH MONTH DAY YEAR: October 23, 1987		2b. HOUR: 4:30 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 05 12 14	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Massachusetts	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Center-The Pines		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School teacher	12b. KIND OF BUSINESS OR INDUSTRY: Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Talbot	13c. CITY OR TOWN: Easton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: RD 3 Box 175 21601	
14. FATHER'S NAME FIRST: Edward	MIDDLE: Grant	LAST: Birge	15. MOTHER'S MAIDEN NAME FIRST: LaRue	MIDDLE: Edna	LAST: Ebaugh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO: 216-14-2698	17. INFORMANT ADDRESS: Beverly B. Lennon 5 Colonial Ct Easton MD 21601		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): LUNG CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 mos

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CA PANCREAS 3 mo

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/14 19 63 to 10/23 19 87 that (I) (we) last saw the deceased alive on 10/14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen Carney M.D. — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10-23-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen P. Carney, M.D. — 22e. ADDRESS: Rt 3 Box 106 Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/27/87	23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery	23d. LOCATION CITY OR TOWN: Easton	COUNTY: Talbot STATE: MD
24. FUNERAL DIRECTOR NAME: Newnam Funeral Home	ADDRESS: Easton, Maryland	25a. DATE RECD. BY REGISTRAR: OCT 26 1987	26b. REGISTRAR'S SIGNATURE	

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

0 6 8390 OCT 1 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 30569 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)	FIRST: MARY	MIDDLE: P.	LAST: Bowser	2a. DATE OF DEATH MONTH: Oct.	DAY: 9,	YEAR: 1987
2b. HOUR	2:05 AM					
3. SEX	Female	4. RACE	B/K	5. DATE OF BIRTH MONTH: 09	DAY: 29	YEAR: 19
6. AGE (IN YEARS LAST BIRTHDAY)	68 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MD.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH	EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Domestic	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	Queen Anne	13c. CITY OR TOWN	Grasonville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS	RT 1 Box 289 21638					
14. FATHER'S NAME FIRST	Charles	MIDDLE		LAST	Kellum	15. MOTHER'S MAIDEN NAME FIRST: Debbie MIDDLE: LAST: Harris
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	—	16b. SOCIAL SECURITY NO.	220-01-1654	17. INFORMANT ADDRESS: James Bowser

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Urosepsis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes, Seizure Disorder, Stroke

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from May 19 87 to 10/9 19 87, that (I) (we) last saw the deceased alive on 10/5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Ludwig J. Eglseder III MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10/10/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ludwig J. Eglseder III MD — 22e. ADDRESS: RT 3 Box 106 Easton md 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	10/14/87	23c. NAME OF CEMETERY OR CREMATORY	Woodlawn Cemetery
23d. LOCATION CITY OR TOWN	Easton	COUNTY	TA	STATE	MD
24. FUNERAL DIRECTOR NAME	Lurge V. Dashiell	ADDRESS	31 Jane St Easton Md	25a. DATE REC'D BY REGISTRAR	OCT 12 1987
25b. REGISTRAR'S SIGNATURE	Julia Davidson-Lindsay				

068915 OCT 19 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 3057

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Lorraine Wood Brock			2a. DATE OF DEATH MONTH / DAY / YEAR: 10 / 11 / 87	2b. HOUR: 11:15 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH / DAY / YEAR: 12 / 31 / 18	6. AGE (IN YEARS LAST BIRTHDAY): 68 years YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 1 HR.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD	
10. CITY OR TOWN OF DEATH: Easton,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 206 Wye Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Talbot	13c. CITY OR TOWN: Easton	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 206 Wye Avenue, Easton, Md. 2160 1
14. FATHER'S NAME FIRST / MIDDLE / LAST: Walter B. Wood			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Eliza M. Russ	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220-03-2369	17. INFORMANT ADDRESS: William Brock 206 Wye Ave Easton MD 21601	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MALIGNANT LYMPHOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 yrs

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 4/18/80, 19____, to 10-11, 19 87, that (I) (we) last saw the deceased alive on 10/08/87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen P. Carney	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10-12-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen P. Carney, M.D.	22e. ADDRESS: Rt. 3, Box 106, Easton, Md. 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/14/87	23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Pk	23d. LOCATION CITY OR TOWN: Easton	COUNTY: Talbot STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Newnam Funeral Home Easton, Maryland		25a. DATE REC'D BY REGISTRAR: OCT 16 1987	25b. REGISTRAR'S SIGNATURE: Julia Denison-Lindsay	

069539 OCT 23 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30571

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, the completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: PHYLLIS	MIDDLE: HARRISON	LAST: BUSH	2a. DATE OF DEATH MONTH DAY YEAR: OCT. 11, 1987	2b. HOUR: 2:50p.M
3. SEX: FEMALE	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 4, 1899	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 1 DAY: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL AT EASTON	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: HOME	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	TALBOT	ST. MICHAELS	YES ☐ NO XX	RIO VISTA RT # 1 BOX 397 21663

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
PHILIP W. HARRISON	ALICE SPARKS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	----------	366-48-0315	HAROLD C. BUSH	RT# 1 BOX 397 ST. MICHAELS MARYLAND 21663

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PNEUMONIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)	
21d. INJURY OCCURRED (WHILE AT WORK ☐ NOT WHILE AT WORK ☐)	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 10/1 19 87 to 10/4 19 87 that I (we) last saw the deceased alive on 9/30 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Wm Bremer	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	10/13/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Wm BREMER MD	ST. MICHAELS Md 21663

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	OCT. 14, 1987	OLIVET CEMETERY	ST. MICHAELS, TALBOT MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard E. Lowe St. Michaels, Md.	OCT 20 1987	Anne Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

071284 NOV 10 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 / 30572

1 DECEASED NAME (TYPE OR PRINT): FIRST FRANK MIDDLE W LAST CAHALL

2a DATE OF DEATH: MONTH 10 DAY 26 YEAR 87

2b HOUR: 9:58 PM

3 SEX: Male

4 RACE: White

5 DATE OF BIRTH: MONTH 10 - DAY 5 - YEAR 20

6 AGE (IN YEARS LAST BIRTHDAY): 67 YRS

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b CITIZEN OF WHAT COUNTRY?: USA

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD

10 CITY OR TOWN OF DEATH: Easton

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer

12b KIND OF BUSINESS OR INDUSTRY: Food

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: Maryland

13b COUNTY: Caroline

13c CITY OR TOWN: Greensboro

13d INSIDE CITY LIMITS? YES [X] NO [ ]

13e STREET ADDRESS: Sunset Ave. 21639

14 FATHER'S NAME: FIRST Edgar MIDDLE F. LAST Cahall

15 MOTHER'S MAIDEN NAME: FIRST Pearl MIDDLE LAST Butler

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes

(IF YES, GIVE WAR OR DATES): WW II

16b SOCIAL SECURITY NO.: 219-03-3261

17 INFORMANT: June Cahall ADDRESS: Greensboro, MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Uncertain

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Status anginosus, ischemic cardiomyopathy and refractory congestive failure

DUE TO, OR AS A CONSEQUENCE OF (c): arteriosclerotic heart disease

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES [ ] NO [ ]

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION: STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 03-28 19 86 to 10-26 19 87 that (I) (we) last saw the deceased alive on 10-26 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Robert W. Trever, M.D. DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]

22c DATE SIGNED: 10-26-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS: RD3 Box 297 Easton, Md. 21601

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b DATE: 10-29-87

23c NAME OF CEMETERY OR CREMATORY: Greensboro Cem.

23d LOCATION: CITY OR TOWN Greensboro COUNTY CA MD

24 FUNERAL DIRECTOR: NAME John E. Boulais ADDRESS Greensboro, MD

25a DATE REC'D BY REGISTRAR: NOV 02 1987

25b REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

15

069211 OCT 21 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 30573

1 - FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): Austin J. Cate

2a. DATE OF DEATH: Oct 18, 1987 — 2b. HOUR: 805 AM

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: 3 27 1910

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cedar Rapid, Iowa

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD

10. CITY OR TOWN OF DEATH: Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SELF-EMPLOYED

12b. KIND OF BUSINESS OR INDUSTRY: RETIRED

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Queen Annes

13c. CITY OR TOWN: CHESTER

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS / ZIP CODE: Cecil DR Chester, md 21619

14. FATHER'S NAME: William Harmon

15. MOTHER'S MAIDEN NAME: EDNA Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): WWII — IF YES, GIVE WAR OR DATES: Yes

16b. SOCIAL SECURITY NO.: 217-26-6695

17. INFORMANT — ADDRESS: MICHAEL CATES - son, Centerville, Md. 21617

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for a, b, and c.
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cachexia of uncertain etiology
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic cirrhosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Progressive end-stage dementia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that I (this hospital) attended the deceased from — 19 85 to 10-18 19 87 that I (we) last saw the deceased alive on 10-12 19 87 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE: Mr Crosby MD for R.B. Sanchez — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 10-18-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MD Krowley

22e. ADDRESS: Easton, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 10-18-87

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION: CITY OR TOWN — COUNTY — STATE

24. FUNERAL DIRECTOR — NAME — ADDRESS: State Anatomy Board Balto., Md.

25a. DATE REC'D BY REGISTRAR: OCT 19 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows injury or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the local registrar of the district in which death occurred. Page 3 is to be retained by the funeral director. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

070096 OCT 29 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 30574

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First Blanche Middle Kendall Last CLARK — Blanche Clark
2a. DATE OF DEATH: Month 10 Day 18 Year 87
2b. HOUR: 5:50 P.M.
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Month November Day 19 Year 1890
6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. If under 1 year: Months ____ Days ____ If under 24 hrs.: Hours ____ Min. ____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.
10. CITY OR TOWN OF DEATH: EASTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SOCIAL FACILITY, GIVE STREET ADDRESS): Memorial HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant(ret.)
12b. KIND OF BUSINESS OR INDUSTRY: Garment

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: QueenAnne's
13c. CITY OR TOWN: Centreville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: R.D. 2, Box 373 21617

14. FATHER'S NAME: First Walter Middle Randolph Last Kendall
15. MOTHER'S MAIDEN NAME: First Emma Middle ---- Last Glenn
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 089-09-5911
17. INFORMANT: Niece ADDRESS: R.D. 2, Box 374
Mrs. Marian K. Leiby, Centreville, Md. 21617

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic acidosis
DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF (c): ____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Anemia, cause not determined. Senility

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO XX
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-17 19 87 to 10-18 19 87 that (I) (we) last saw the deceased alive on 10-16 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert W. Trever, M.D.
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10-18-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert W. Trever, MD
22e. ADDRESS: RD3 Box 297 Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct. 21, 1987
23c. NAME OF CEMETERY OR CREMATORY: Church Hill Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE: Church Hill, Q.A.Co., Md.

24. FUNERAL DIRECTOR NAME: Barton Funeral Home ADDRESS: James H. Barton, Jr., Centreville, Md. 21617
25a. DATE REC'D. BY REGISTRAR: OCT 26 1987
25b. REGISTRAR'S SIGNATURE: [signature]

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

069403 OCT 23 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mac	MIDDLE	LAST: Conway	2a. DATE OF DEATH MONTH: September	DAY: 5	YEAR: 1987
2b. HOUR: 8:40 AM					
3. SEX: F	4. RACE: B	5. DATE OF BIRTH MONTH: 3	DAY: 11	YEAR: 1924	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VA	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Md	13b. COUNTY: Dor	13c. CITY OR TOWN: Cambridge	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 1501 Myrtle Ave 21613	
14. FATHER'S NAME FIRST: Unk	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST: Unk	MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Metastatic Colon Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Nearly 3 yrs
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital) attended the deceased from 7/21, 19 87 to 9/5, 19 87, that (I) (we) last saw the deceased alive on 9/5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ludwig F. Eglseder III MD	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 9/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ludwig F. Eglseder III MD	22e. ADDRESS: RT 3 Box 106 Dutchmans Lane Easton Md 21601		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): B	23b. DATE: 9/7/87	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME: Earl Dashiell Sr.	ADDRESS: Box 606 Easton Md	25a. DATE RECD. BY REGISTRAR: OCT 20 1987	25b. REGISTRAR'S SIGNATURE: [illegible]	

4

071060 NOV 6 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 30576

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstance, the medical examiner must be notified at once.

1. DECEASED NAME (FIRST / MIDDLE / LAST)	Mary	E.	Fisher	2a. DATE OF DEATH (MONTH DAY YEAR)	October 27, 1987
2b. HOUR	10:00AM				
3. SEX	Female	4. RACE	Cauc.	5. DATE OF BIRTH (MONTH DAY YEAR)	Oct 5, 1912
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	North Carolina	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XXX DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Talbot MD				
10. CITY OR TOWN OF DEATH	Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Meridian - The Pines Easton	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	----				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Talbot	Easton	YES ☐ X NO ☐	21601 UNKNOWN

14. FATHER'S NAME (FIRST / MIDDLE / LAST)	15. MOTHER'S MAIDEN NAME (FIRST / MIDDLE / LAST)
Philip Edmond	Mary E. Barkman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	------	213-03-0354	Philip E. Fisher	2515 St. Paul Street Baltimore, Maryland 21218

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA RECTUM — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: FEW (S)

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 10/27/87 19____ to 10/27/87 19____ that (I) (we) last saw the deceased alive on 10/27/87 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
C.R.W. Bain	M.D.	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☒	STAFF PHYSICIAN ☐	10/27/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C.R.W. BAIN	415 E. DOVER, EASTON, MD. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Oct 28, 1987	Lee Crematory	Clinton P. G. Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harrison E. Leonard, Dr. Michaels MD	NOV 02 1987	Davidson Randall

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

070359 OCT 30 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. B/ 30577

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: FREDERICK	MIDDLE: B.	LAST: FOX	2a. DATE OF DEATH MONTH DAY YEAR: 10 23 87	2b. HOUR: 820 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 01 17 27	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Executive	12b. KIND OF BUSINESS OR INDUSTRY: Food Processor	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Talbot	Queen Anne	YES [ ] NO [X]	Rt 303 21657

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Harry		Fox	Esther		Lipman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW II	218-20-8569	Betty H Fox	P O Box 253 Queen Anne MD 21657

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) NON SMALL CELL LUNG CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 MO

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 8-13, 1987, to 10-23, 1987, that (I) (we) last saw the deceased alive on 10-23, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Stephen P. Carney	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	10-24-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stephen P. Carney, M.D.	Dutchman's Lane Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	10/26/87	Woodlawn Memorial Pk	Easton	Talbot	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	OCT 29 1987	

0700048 OCT 28 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30578

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CHARLES	MIDDLE: H.	LAST: HART	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH: 10 DAY: 20 YEAR: 1987	2b. HOUR: M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 26, 1917	6. AGE (IN YEARS) LAST BIRTHDAY: 70 YRS	IF UNDER 1 YR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH: 10 DAY: 20 YEAR: 1987	2d. HOUR: 5:14 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot County MD			
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt. 404 between Church La. & Connelly Rd.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Carrier U.P.S.			

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Anne Arundel	Pasadena	YES [ ] NO [X]	54 Johnson Rd 21122

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Jacob / / Hart	Eva / / Duckett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	**(IF YES, GIVE WAR OR DATES)**	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT / ADDRESS**
Yes	WW II	217 07 5648	Violet L. Hart (Same as 13a-e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	P.M. 10-20-1987	Driver of auto/fixed object impact.

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [X]	road	Rt. 404 between Church Lane &, Connelly Rd. / Talbot, / MD

22a. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [ ] Inquiry [ ] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Ann Dixon M.D. TITLE (SPECIFY): Deputy Chief MEDICAL EXAMINER DATE SIGNED: 10-21-87

EXAMINER'S NAME (TYPE OR PRINT): Ann M. Dixon, M.D. ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Oct.23,1987	Maryland Veterans Cem.	Crownsville / Anne Arundel / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
McCully Funeral Homes 3804 Mountain Rd. Pasadena, MD 21122	OCT 27 1987	Julia Davidson-Landeck

07/84 25M BP____ DHMH - 17 (VR A15 ME (5))

067935 OCT -8 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 305 79 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 lists any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Nora	MIDDLE: M	LAST: Henry	2a. DATE OF DEATH MONTH DAY YEAR: Oct. 1 1987
2b. HOUR: 11:55 AM			
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: DEC. 23, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	TALBOT	EASTON	YES [X] NO [ ]	220 TRED AVON 21601

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
OLIVER MIKESELL	MARTHA KUNKLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		218-20-7548	HARRY H. HENRY see item 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 28 Sept, 19 87, to 1 Oct, 19 87, that (I) (we) last saw the deceased alive on ____, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Andrew McCarty MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	10-2-1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ANDREW DENIS McCARTY	22e. ADDRESS: EASTON, MARYLAND 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	10-5-1987	GREENWOOD CEM.	INDIANA, INDIANA, PENNA.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
NEWNAM FUNERAL HOME EASTON, MD.	OCT 07 1987	Julia Davidson-Randall

068393 OCT 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30586

REG. NO.

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS: 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT): First: Maggie; Middle: May; Last: Howell
2a. DATE OF DEATH: Month/Day/Year: 10/1/87
2b. HOUR: 5:50 p.m.
3. SEX: Female
4. RACE: B/K
5. DATE OF BIRTH: Month/Day/Year: 08/06/99
6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.
If under 1 year: Months / Days
If under 1 day: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD
10. CITY OR TOWN OF DEATH: Easton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian - the Pines
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Talbot
13c. CITY OR TOWN: Easton
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET ADDRESS / ZIP CODE: RFD 5 Box 78 21601

14. FATHER'S NAME: First: Walter; Middle: S.; Last: Wallace
15. MOTHER'S MAIDEN NAME: First: Carrie; Middle: Gibson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.:
17. INFORMANT: William Howell; ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov. 1 19 82 to 10/1 19 87 that (I) (we) last saw the deceased alive on 9/17 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: WB Bremer
DEGREE: MD
ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wm BREMER MD
22e. ADDRESS: ST. MICHAELS Md 21663

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10/5/87
23c. NAME OF CEMETERY OR CREMATORY: Royal Oak Cemetary
23d. LOCATION: CITY OR TOWN: Easton; COUNTY: TA; STATE: MD
24. FUNERAL DIRECTOR: NAME; ADDRESS:
25a. DATE REC'D. BY REGISTRAR: OCT 12 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

069457 OCT 23 87 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 305361

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Helen — MIDDLE: m — LAST: Huffnagle

2a. DATE OF DEATH — MONTH DAY YEAR: Oct. 19 1987

2b. HOUR: 2:10 AM

3. SEX: F

4. RACE: W

5. DATE OF BIRTH — MONTH DAY YEAR: 10 9 11

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS

IF UNDER 1 YEAR — MONTHS / DAYS:

IF UNDER 24 HRS. — HOURS / MIN.:

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot Co. MD.

10. CITY OR TOWN OF DEATH: Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): UNK.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY: TALBOT

13c. CITY OR TOWN: EASTON

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 201 A. FIRST ST. 21620

14. FATHER'S NAME — FIRST MIDDLE LAST: WILLIAM JACOB JOHNSTON

15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: EMMA MARIE FAITHFUL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 213-12-6335

17. INFORMANT — ADDRESS: RICHARD HUFFNAGLE - husband s/a

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Massive Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 72h

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD — 4YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/16, 19 87, to 10/19, 19 87, that (I) (we) last saw the deceased alive on 10/19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 10/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT):

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 10-20-87

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION — CITY OR TOWN COUNTY STATE:

24. FUNERAL DIRECTOR — NAME: State Anatomy Board — ADDRESS: Balto., Md.

25a. DATE REC'D BY REGISTRAR: OCT 21 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

4

069508 OCT 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30582
REG. NO

1 - FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): FIRST Franklin MIDDLE Elwood LAST JEWELL
   Franklin E. Jewell
2a. DATE OF DEATH: MONTH 10 DAY 14 YEAR 87
2b. HOUR 2:05 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH January DAY 8, YEAR 1933
6. AGE (IN YEARS LAST BIRTHDAY): 54 YRS
   IF UNDER 1 YEAR: MONTHS DAYS
   IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD
10. CITY OR TOWN OF DEATH: Easton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter
12b. KIND OF BUSINESS OR INDUSTRY: Housing & Bridge Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: QueenAnne's
13c. CITY OR TOWN: Grasonville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: P.O.Box 311, 21638

14. FATHER'S NAME: FIRST George MIDDLE Jacob LAST Jewell
15. MOTHER'S MAIDEN NAME: FIRST Barbara MIDDLE ---- LAST Salitzka
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 214-32-1037
17. INFORMANT: Wife ADDRESS: P.O.Box 311
Mrs. Barbara E. Jewell, Grasonville, Md21638

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Amyotrophic lateral sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 6 19 85 to 19 that (I) (we) last saw the deceased alive on 10/13 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Gary J Sprouse MD DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 10/14/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Gary J. Sprouse
22e. ADDRESS: Queenstown, Maryland 21658

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct.16,1987
23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery
23d. LOCATION: CITY OR TOWN Centreville COUNTY Q. A. Co., STATE Md.
24. FUNERAL DIRECTOR (NAME) Barton Funeral Home (ADDRESS) James H. Barton, Jr., Centreville, Md. 21617
25a. DATE REC'D. BY REGISTRAR: OCT 19 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

068803 OCT 6 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B7 30585

REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be completed promptly, filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Pages 1 and 2 should be forwarded within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

1 DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR	
Donald	Oscar	Lyons	Sept. 24, 1987	1:00a	M
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
male	white	June 14, 1934	53 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH		
Md.	U.S.A.		Talbot MD		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
Trappe	Old Trappe Rd.		carpenter		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Md.	Talbot	Trappe	YES ☐ NO ☒	Rt. 2 Box 33 21673

14 FATHER'S NAME FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Oscar	T.	Lyons	Louise		Sharpf

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Yes	1957-1958	214-32-1315	Guinevere M. Lyons Trappe Md. 21673	Rt 2 Box 33

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Renal failure	6 mo
DUE TO, OR AS A CONSEQUENCE OF (b)	AMYLOIDOSIS	5 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)	MULTIPLE MYELOMA	5 YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from June 19 82 to 9/24 19 87 that (I) (we) last saw the deceased alive on 9/15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	9-21-87
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS	

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
burial	9/26/87	Dor. Memorial Park	Cambridge Dor. Md.

24 FUNERAL DIRECTOR NAME	ADDRESS	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
THOMAS FUNERAL HOME	CAMBRIDGE MD.	OCT 02 1987	Julia Davidson-Randall

BP

DHMH 16 60M 7/84 (VRA 15, 4)

067931 OCT -8 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 30584

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: Wesley	LAST: MARSHALL	2a. DATE OF DEATH MONTH DAY YEAR: 10 3 87	2b. HOUR: 1145 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: January 24, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): State Employee	12b. KIND OF BUSINESS OR INDUSTRY: Retired		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Dorchester	Cambridge	YES ☐ NO XX	Rt 1 Box 511 21613

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	James	Marshall	Clara		Brannock

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW II	214-18-4008	Hazel R. Marshall Item # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Septic shock	2-3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Post operative state	6 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Ruptured abdominal aneurysm	7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Acute renal insufficiency

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 10-2 19 87 to 10-3 19 87, that (I) (we) last saw the deceased alive on 10-3 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Lawrence D. Bohan MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LAWRENCE D. BOHAN MD	HOM HOSP EASTON MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10/6/87	Dor. Memorial Park	Cambridge Dor Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
THOMAS FUNERAL HOME	CAMBRIDGE, MD.	OCT 07 1987	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

Hosp.sent new D.C. 11/2/87

070644 NOV -3 '87

FOR STATE REGISTRAR Film G633 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 30385

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Evelyn	MIDDLE: W.	LAST: Moore	2a. DATE OF DEATH MONTH: 10	DAY: 23	YEAR: 87
2b. HOUR: 8:30P M					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 5, 1922	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Caroline	13c. CITY OR TOWN: Federalsburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 220 Maple Avenue	21632
14. FATHER'S NAME FIRST: David	MIDDLE	LAST: Williams	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: Bullock	LAST: Williams
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-16-6605	17. INFORMANT: J.Wm. Moore	ADDRESS: 220 Maple Ave. Federalsburg, Md	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Antero-septal myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artery disease, severe — years

DUE TO, OR AS A CONSEQUENCE OF (c): diabetes mellitus — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Myocardial infarction postero LV, old

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Reinhardt O. Sahmel	DEGREE: MD	ATTENDING PHYSICIAN ☐ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	Pathologist
22c. DATE SIGNED: 10/23/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Reinhardt O. Sahmel	22e. ADDRESS: Lab, Easton Mem. Hospital		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/26/87	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Federalsburg, Caroline, Md
24. FUNERAL DIRECTOR NAME: Frampton-Hawkins	ADDRESS: 216 N. Main St., Federalsburg, Md.	25a. DATE REC'D BY REGISTRAR: NOV 02 1987	25b. REGISTRAR'S SIGNATURE: Lois Davidson-Landeo

BP_____

DHMH 1650M 1/81 (VRA 15, 4)

3

069196 OCT 2087

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and may

BP_____

DHMH 16 50M 1/81
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 30586

1. DECEASED NAME (TYPE OR PRINT): FIRST Margaret MIDDLE Ferrick LAST MOORE
   MARGARET MOORE
2a. DATE OF DEATH: MONTH Oct. DAY 5 YEAR 1987
2b. HOUR: 10:00 AM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH August DAY 16 YEAR 1893
6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS. IF UNDER 1 YEAR: MONTHS ____ DAYS ____ IF UNDER 24 HRS.: HOURS ____ MIN ____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH: Easton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Wife
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: QueenAnne's
13c. CITY OR TOWN: Centreville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: R.D. 1, Box 172, 21617

14. FATHER'S NAME: FIRST James MIDDLE ---- LAST Ferrick
15. MOTHER'S MAIDEN NAME: FIRST Frances MIDDLE ---- LAST Walker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 212-52-0981
17. INFORMANT: Daughter ADDRESS: R.D. 2, Box 6-S
Mrs. Margaret M. Wright, Denton, Md. 21629

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Aspiration with Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Frontal Lobe Infarct. — 2 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c): Cerebrovascular Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/5 8 19 87 to 10/5 19 87 that (I) (we) last saw the deceased alive on 10/5 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wm H Wood — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wm H Wood
22e. ADDRESS: Easton Md 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct. 8, 1987
23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery
23d. LOCATION: CITY OR TOWN Centreville, COUNTY Q.A.Co., STATE Md.
24. FUNERAL DIRECTOR (NAME, ADDRESS): Barton Funeral Home
James H. Barton, Jr., Centreville, Md. 21617
25a. DATE REC'D. BY REGISTRAR: OCT 13 1987
25b. REGISTRAR'S SIGNATURE: [illegible]

068881 OCT 1987 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30587

REG. NO

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

1. DECEASED NAME (TYPE OR PRINT) First: WILLIAM Middle: RUSSELL Last: MORGAN, Jr.				2a. DATE OF DEATH Month Day Year: Sept 14 87	2b. HOUR: 3:58AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: July 24, 1925	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Easton Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Food Inspector	12b. KIND OF BUSINESS OR INDUSTRY: Agriculture	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Dorchest.	13c. CITY OR TOWN: Hurlock	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: Rt. 2, Box 70	21643
14. FATHER'S NAME First: William Middle: Russell Last: Morgan, Sr.			15. MOTHER'S MAIDEN NAME First: Mamie Middle: Ivins Last: Morgan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO: 218-20-9565	17. INFORMANT: Elizabeth Morgan, Rt. 2, Box 70	ADDRESS: Hurlock, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	CARDIAC ARRHYTHMIA	1 MINUTE
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY ARTERY DISEASE	5 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): CHR. OBSTR. PULMONARY EMPHYSEMA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/30 19 84 to 9/14 19 87 that (I we) last saw the deceased alive on 9/17 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE: Stephen B Cunningham	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10-14-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 9/17/87	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Federalsburg, Caroline, MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: FRAMPTOM-HAWKINS, PO Box 43, Federalsburg, Md.	25a. DATE REC'D. BY REGISTRAR: OCT 16 1987	25b. REGISTRAR'S SIGNATURE: Linda Dickson-Lankford		

BP

DHMH 16 60M 7/73
(VR A 15(4))

068969 OCT 20 87 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 30586

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

BP_____

DHMH 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Vernon	MIDDLE: D.	LAST: Penner	2a. DATE OF DEATH MONTH DAY YEAR: 10-14-87	2b. HOUR: 9:50 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 03 19 05	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD	
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrical Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	Easton	YES [ ] NO [X]	Rt 5 Box 709 21601

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Marvin	William	Penner	Lila		DuBois

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		090-03-3250	Edna B. Penner	Rt 5 Box 709 Easton MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Probable MI	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old IMI, Lanteus Ca, ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/5 19 84 to 10/10 19 87 that (I) (we) last saw the deceased alive on 10/10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
George Cavanagh	MD	[ ] [ ] [ ]	10/15/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
George Cavanagh, M.D.	508 Idlewild Avenue Easton, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10/17/87	New Paltz Rural Cemetery	New Paltz Ulster N.Y.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	OCT 19 1987	Julia Davidson-Lindsay

071013 NOV 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 30589

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: SONIA	MIDDLE: M.	LAST: REID	2a. DATE OF DEATH MONTH DAY YEAR: October 31 1987	2b. HOUR: 11P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 23 17	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	Easton	YES [ ] NO [X]	Rt 5 Box 382

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frank	G.	Michel	Catherine		Kirk

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		216-09-1990	J. Edward Reid Rt 5 Box 382 Easton MD 21601

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of the Breast — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 YRS

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/16 1987 to 10/31 87 that (I) (we) last saw the deceased alive on 10/31 1987 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (certified) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Donald T. Lewers M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	10/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Donald T. Lewers, M.D.	Dutchman's Lane Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	11/3/87	Salisbury Crematory	Salisbury	Wicomico	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	NOV 5 1987	

070913 NOV -5 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 030570

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then piece remaining pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Effie MIDDLE: Anderson LAST: Rhodes				2a. DATE OF DEATH MONTH DAY YEAR: 10-26-87	2b. HOUR: 4:55 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 3, 1888		6. AGE (IN YEARS LAST BIRTHDAY): 98 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD	
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Q.A.	13c. CITY OR TOWN: Chester	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 21619	
14. FATHER'S NAME FIRST MIDDLE LAST: James M. Anderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Nannie Bauer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-74-4858	17. INFORMANT ADDRESS: W. Edgar Rhodes, Jr., Rt. 1 Box 531, 21619		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10-23, 19 87, to 10-26, 19 87, that (I) (we) last saw the deceased alive on 10-26, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P Bardetch MD	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10-26-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Patricia Bardetch, MD	22e. ADDRESS: Centreville, Maryland 21617	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/27/87	23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Mausoleum	23d. LOCATION CITY OR TOWN: Baltimore COUNTY: Balt. STATE: MD	
24. FUNERAL DIRECTOR NAME ADDRESS: Tom Helfenbein Funeral Home, Chester, MD 21619		25d. DATE REC'D BY REGISTRAR: OCT 30 1987	25b. REGISTRAR'S SIGNATURE:	

070362 NOV -2 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30591 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1 DECEASED NAME (TYPE OR PRINT) FIRST: Daisy	MIDDLE: O.	LAST: Sard	2a DATE OF DEATH MONTH DAY YEAR: October 28, 1987	2b HOUR: 3:40 PM	
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH MONTH DAY YEAR: 10 08 22	6 AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.		
10 CITY OR TOWN OF DEATH: Easton	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Seamstress	12b KIND OF BUSINESS OR INDUSTRY: Interior Decorating		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE: Maryland	13b COUNTY: Talbot	13c CITY OR TOWN: Easton	13d INSIDE CITY LIMITS? YES X NO ☐	13e STREET ADDRESS: 201 Federal St Apt 25	21601
14 FATHER'S NAME FIRST: George	MIDDLE: L.	LAST: Jackson	15 MOTHER'S MAIDEN NAME FIRST: Ethel	MIDDLE	LAST: McQuay
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.: 216-40-4576	17 INFORMANT ADDRESS: William Ashley Sard 201 Federal St Easton MD		

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Breast Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 mos
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a I certify that (I) (this hospital) attended the deceased from 5-29 19 85 to 10-28 19 87, that (I) (we) last saw the deceased alive on 10-28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Stephen P Carney — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR X STAFF PHYSICIAN ☐ — 22c DATE SIGNED: 10-28-87

22d PHYSICIAN'S NAME (TYPED OR PRINTED): Stephen P. Carney, M.D. — 22e ADDRESS: Dutchman's Lane Easton, Maryland 21601

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b DATE: 10/31/87	23c NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery	23d LOCATION CITY OR TOWN: Easton	COUNTY: Talbot STATE: MD
24 FUNERAL DIRECTOR NAME: Newnam Funeral Home	ADDRESS: Easton, Maryland	25a DATE REC'D BY REGISTRAR: OCT 30 1987	25b REGISTRAR'S SIGNATURE: Gordon Lindsay	

067934 OCT - 8187 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 30592

1. DECEASED NAME (TYPE OR PRINT) FIRST: ADELE	MIDDLE: O.	LAST: SARVEY	2a. DATE OF DEATH MONTH DAY YEAR: 10-4-87	2b. HOUR: 838P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 02 15 31	6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS. HOURS MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Licensed Prat. Nurse	12b. KIND OF BUSINESS OR INDUSTRY: Medical		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	St. Michaels	YES [X] NO [ ]	106 Marengo Street 21663

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James	Matthew	Lewis	Floy	Ann	Windsor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		217-28-3637	Paul G. Sarvey	106 Marengo St St Michaels MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intra Cranial hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c): Intra Cranial Aneurysm

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 87, to 10-4, 19 87, that I (we) last saw the deceased alive on 10-4, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Terry P. Detrich	MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	10/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Terry P. Detrich, M.D.	140 S. Washington St, Easton, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	10/7/87	Md. Veterans' Cemetery	Hurlock	Dorchester	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	OCT 07 1987	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

066380 SEP 22 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 30593 REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST: SARAH MIDDLE: H LAST: SMITH

7a DATE OF DEATH KNOWN ☑ ESTIMATED ☐ MONTH: 7 DAY: 21 YEAR: 1987

2b HOUR: 7 54 M

3 SEX: F

4 RACE: B

5 DATE OF BIRTH MONTH DAY YEAR: UN

6 AGE (IN YEARS) (LAST BIRTHDAY) YRS: UN IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN

2c DATE PRONOUNCED DEAD MONTH: 7 DAY: 21 YEAR: 1987

2d HOUR: 7 54 M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md

7b CITIZEN OF WHAT COUNTRY?: US

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD

10 CITY OR TOWN OF DEATH: Easton

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Easton Mem

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor

12b KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: MD

13b COUNTY: CAROLINE

13c CITY OR TOWN: Greensboro

13d INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS: Rural 21636

14 FATHER'S NAME FIRST: Unk MIDDLE LAST

15 MOTHER'S MAIDEN NAME FIRST: Unk MIDDLE LAST

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.: Unk

17 INFORMANT: Hospital Records ADDRESS

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a: PROBABLE HYPERTHERMIA

19a DATE OF OPERATION:

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20 AUTOPSY? YES ☐ NO ☑

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Ludwig J. Eglseder III M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 7/21/87

EXAMINER'S NAME (TYPE OR PRINT): Ludwig J. Eglseder III MD ADDRESS:

23a BURIAL, CREMATION, REMOVAL (SPECIFY): B

23b DATE: 7/24/87

23c NAME OF CEMETERY OR CREMATORY: Caters

23d LOCATION CITY OR TOWN: Greensboro COUNTY: Caroline STATE: Md

24 FUNERAL DIRECTOR NAME: Eric Pritchett ADDRESS: Easton MD

25a DATE REC'D BY REGISTRAR: SEP 18 1987

25b REGISTRAR'S SIGNATURE: Julia Davidson-Landrum

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 2566 BP

DHMH - 17 (VR A15 ME (5))

069560 OCT 23 '87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30594

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

1. DECEASED NAME (TYPE OR PRINT) FIRST: GLENN	MIDDLE: A. S.	LAST: STARTT	2a. DATE OF DEATH MONTH DAY YEAR: 10-18-87	2b. HOUR: 750P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 13 13	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner/Operator	12b. KIND OF BUSINESS OR INDUSTRY: General Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Maryland	13b. COUNTY: Talbot	13c. CITY OR TOWN: Easton	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 111 Prospect Avenue 21601	
14. FATHER'S NAME FIRST: Edward	MIDDLE: Kenly	LAST: Startt	15. MOTHER'S MAIDEN NAME FIRST: Nora	MIDDLE	LAST: Stewart
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-01-6320	17. INFORMANT: Christine S. Startt	ADDRESS: 111 Prospect Ave Easton MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Cerebral Metastasis

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of Lung

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/16, 19 87, to 10/18, 19 87, that (I) (we) last saw the deceased alive on 10/18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Rebecca Rhodes MD — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 10/19/87

22d. PHYSICIAN'S NAME (TYPED OR PRINTED): REBECCA RHODES MD

22e. ADDRESS: 503 DUTCHMAN'S LANE, EASTON, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/22/87	23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery	23d. LOCATION CITY OR TOWN: Easton	COUNTY: Talbot STATE: MD
24. FUNERAL DIRECTOR NAME: Newnam Funeral Home	ADDRESS: Easton, Maryland	25a. DATE REC'D BY REGISTRAR: OCT 22 1987		

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

3

069197 OCT 20-87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30595

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: ~~MARY~~ MIDDLE: ~~CATHERINE~~ LAST: STAUFFER				2a. DATE OF DEATH MONTH DAY YEAR: October 7, 1987	2b. HOUR: 3 p.m.
3. SEX: Female	4. RACE: Cau.	5. DATE OF BIRTH MONTH DAY YEAR: December 24, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot County MD		
10. CITY OR TOWN OF DEATH: Neavitt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): At HOme - Rural		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: -----	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Talbot	Neavitt	YES [ ] NO [X]	21652 Rural

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Martin Oravec	Anna Oravec

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
~~Cremation~~	No	194-22-6382	D. Earl Stauffer	Neavitt, Md., 21652

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) TERMINAL METASTATIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/5 19 87 to 10/7 19 87 that (I) (we) last saw the deceased alive on 10/5 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
WS Bremer	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	10/7/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Wm BREMER MD	ST. MICHAELS Md 21663

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Oct 8, 1987	Lee Crematory	Clinton Prince George's MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harrison E. Lenard, St. Michaels, Md.	OCT 14 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please forward the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

068455 OCT 14 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

M.C. - 10417281

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified before removal.

BP_____

DHMH 16 50M 1/81
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 030970

1 DECEASED NAME (TYPE OR PRINT) First: George Middle: L. Last: Taylor, Sr. — George Lewis Taylor

2a DATE OF DEATH Month Day Year: Oct. 6 1987 — **2b HOUR**: 7:26 A.M.

3 SEX: Male

4 RACE: White

5 DATE OF BIRTH Month Day Year: March 19 1913

6 AGE (IN YEARS LAST BIRTHDAY): 74 YRS — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto, Md.

7b CITIZEN OF WHAT COUNTRY?: USA

8 MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD

10 CITY OR TOWN OF DEATH: Easton

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Correctional Officer & Waterman

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: Md. — **13b COUNTY**: Queen Anne — **13c CITY OR TOWN**: Chester — **13d INSIDE CITY LIMITS?** YES [X] NO [ ] — **13e STREET ADDRESS**: Rt. #1 Box 58 Dundee Avenue Chester Md 21619

14 FATHER'S NAME First Middle Last: Frank Seth Taylor Sr.

15 MOTHER'S MAIDEN NAME First Middle Last: Elizabeth Schleicher

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.: 218-14-7303

17 INFORMANT: Mary Elmyra Taylor — ADDRESS: Rt. #1 Box 58 Dundee Ave Chester, Md. 21619

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio - Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 40 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Embolys

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Total knee replacement.

19a DATE OF OPERATION: 9.29.87

19b CONDITION FOR WHICH OPERATION WAS PERFORMED: Degenerative Joint Disease

20a AUTOPSY? YES [ ] NO [X]

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Myczumr — **DEGREE**: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT): Myrow J. Szczukowski Jr. M.D.

22e ADDRESS: 32. S. Washington St. Easton, Md.

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b DATE: 10-8-87

23c NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park

23d LOCATION CITY OR TOWN: Easton COUNTY: Talbot STATE: Md.

24 FUNERAL DIRECTOR NAME AND ADDRESS: Helfenbein Funeral Home Chester, Md.

25a DATE RECD. BY REGISTRAR: OCT 13 1987

25b REGISTRAR'S SIGNATURE: Julia Davidson-Randall

067933 OCT 8-87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30517 REG. NO

1 DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
Emma		Todd	10/3/87	8:40 a. M

3 SEX	4 RACE	5 DATE OF BIRTH Month Day Year	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months	Days	IF UNDER 1 DAY Hours	Min.
Female	White	Feb 16, 1910	77 YRS.				

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH
New Jersey	US		Talbot MD

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Easton	Meridian - The Pines	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Maryland	Dorchester	Cambridge	YES XX NO ☐	414 Edlon Park 21613

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Anthony	P.	Hinsky	Amelia		Grandy 07450

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
No		133-18-8093	Vincent A. Andrews	442 VanEmbrugh Ave Ridgewood, N.J.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebro vascular Accident

DUE TO, OR AS A CONSEQUENCE OF: (b) Cerebral Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF: (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a I certify that (I) (this hospital) attended the deceased from May 1981 to October 1987 that (I) (we) last saw the deceased alive on October 1 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
W. Mitchell Wood	MD ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/5/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
William H. Wood, Jr., M.D.	Rt. 3, box 106, Easton, Md. 21601

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN	COUNTY	STATE
Entombment	10/6/87	Cypress Hills Abbey	Brooklyn		New York

24 FUNERAL DIRECTOR NAME	ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Thomas Funeral Home		OCT 07 1987	Julia Davidson-Kennedy

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP

DHMH - 16 60M 7 84
(VRA 15, 4)

68965 OCT 20 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

1 DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
DIANE	H	TRICE	October 15 1987	5:42 AM

3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	07 23 40	47 YRS.		

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8	9 BALTIMORE CITY OR COUNTY OF DEATH
Delaware	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	TALBOT MD

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
EASTON	MEMORIAL HOSPITAL	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS
Maryland	Talbot	Easton	YES ☒ NO ☐	705 Goldsborough Street 21601

14 FATHER'S NAME FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	J.	Curlett, Sr	Helen	F.	Newcomb

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
no		221-26-1722	Donna M Donaldson 202 Mulberry Hills Apts.	Easton MD 21601

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Ca (R) Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 YRS

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☒ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a I certify that (I) (this hospital) attended the deceased from 5/13 19 71 to 10/14 19 87 that (I) (we) last saw the deceased alive on 10/14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
James C. Gieske	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/17/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
James C. Gieske, M.D.	505 Dutchman's Lane Easton MD 21601

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN	COUNTY	STATE
Burial	10/17/87	Spring Hill Cemetery	Easton	Talbot	MD

24 FUNERAL DIRECTOR NAME	ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	OCT 19 1987	Norma Lindsey

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

069565 OCT 22 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 30599

REG. NO.

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury or other traumatic event, the medical examiner must be notified of the case.

1. DECEDENT'S NAME (INCLUDE AKA'S IF ANY) — FIRST: Ruth — MIDDLE: ELIZABETH — LAST: White			2a. DATE OF DEATH — MONTH DAY YEAR: 10-14-87	2b. HOUR: 240 PM
3. SEX: female	4. RACE: white	5. DATE OF BIRTH — MONTH DAY YEAR: Apr. 17, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DEL.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.	
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): homemaker	12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Dor.	Cambridge	YES ☒ NO ☐	701 Race St. 21613

14. FATHER'S NAME — FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST
John Bogart Curtis	Laura Baker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		218-20-7681	John C. White	Cambridge Md. 1306 Glasgow St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-2 hrs

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Multiple Myeloma, e coli sepsis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-28 19 87 to 10-14 19 87, that (I) (yes) last saw the deceased alive on 10-13 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Lawrence D. Bohan MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LAWRENCE D. BOHAN	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
burial	10/17/87	Richardson Family	Cambridge Dor. Md.

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
THOMAS FUNERAL HOME CAMBRIDGE MD.	OCT 22 1987	Julia Richardson Registrar

BP

DHMH - 16 50M 1/81 (VRA 15. 4)

070538 NOV -8 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 030 00

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Anita	MIDDLE	LAST: Williams	2a. DATE OF DEATH MONTH: 10 DAY: 25 YEAR: 87	2b. HOUR: 6:30 A.M.	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH: 1 DAY: 1 YEAR: 23	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Education		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Caroline	Preston	YES ☐ NO ☑	Box 418 21655

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Henry Benjamin Showell	Viola Showell	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES):	17. INFORMANT: Joseph Williams ADDRESS: Box 418 Preston, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Colon cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 mo
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 4-30 19 87 to 10-25 19 87 that (I) (we) last saw the deceased alive on 10-24 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was not~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Sylvia Campbell	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10-25-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10-29-87	Pullett	Wicomico Memorial Gardens Salisbury Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bennie L. Smith	Box 228 Hurlock, Md.	NOV 02 1987	Julia Gordon-Kendall

069496 OCT 23 1987 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 006041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ZORA MIDDLE: W LAST: Willin			2a. DATE OF DEATH MONTH DAY YEAR: 10-14-87
2b. HOUR: 10:20 A M			
3. SEX: Male	4. RACE: Cau.	5. DATE OF BIRTH MONTH DAY YEAR: July 25 1891	6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS.
IF UNDER 1 YEAR MONTHS / DAYS:	IF UNDER 24 HRS. HOURS / MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Eldorado, Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Merchant- general store	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Md.	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Eldorado	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: P.O.Box 167 Rhodesdale, Md.			
14. FATHER'S NAME FIRST: Jacob MIDDLE: T. LAST: Willin		15. MOTHER'S MAIDEN NAME FIRST: Sally MIDDLE: Ann LAST: Stevens	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-22-6142	17. INFORMANT ADDRESS: Alice Wilson, P.O. Box 167 Rhodesdale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b): High output failure and arteriosclerotic Heart disease

DUE TO, OR AS A CONSEQUENCE OF (c): Myelophthisic anemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Uncertain

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10-10, 19 87, to 10-14, 19 87, that (I) (we) last saw the deceased alive on 10-14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Robert W. Trever, M.D.	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10-15-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert W. Trever, M.D.	22e. ADDRESS: RD 3 Box 297 Easton, Md. 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Oct. 17, 1987	23c. NAME OF CEMETERY OR CREMATORY: Eldorado Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Eldorado, dorchester Md
24. FUNERAL DIRECTOR NAME: Williamson Funeral Home ADDRESS: Federalsburg, Md.	25a. DATE REC'D. BY REGISTRAR: OCT 19 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 87 / 305042

070127 OCT 29 87

1. DECEASED NAME (TYPE OR PRINT): FIRST MARIE MIDDLE Estelle LAST WRIGHT
2a. DATE OF DEATH: MONTH 10 DAY 17 YEAR 87
2b. HOUR: 5:40 AM
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH Oct. DAY 23, YEAR 1890
6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 1 HOUR: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.
10. CITY OR TOWN OF DEATH: EASTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher
12b. KIND OF BUSINESS OR INDUSTRY: Public Sch/

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Caroline
13c. CITY OR TOWN: Choptank
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: Choptank, Preston, Md. 21655

14. FATHER'S NAME: FIRST William MIDDLE James LAST Wright
15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE E. LAST Hawes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 220-44-1880
17. INFORMANT: Lister Jump ADDRESS: 5 S. Greenfield Ave. Hampton Va. 23666

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Oesophageal perforation
DUE TO, OR AS A CONSEQUENCE OF (b): Oesophageal Cancer
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: 10/14/87 - EGD oesoph dilatation
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Oesophageal obstruction 2° Ca
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from August 17, 19 87 to October 17 19 87, that (I) (we) last saw the deceased alive on 10/16 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Monica Agree MD
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Monica Agree MD
22e. ADDRESS: Denton, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10-19-87
23c. NAME OF CEMETERY OR CREMATORY: Choptank Cemeetry
23d. LOCATION: CITY OR TOWN Choptank COUNTY Caroline STATE Md.

24. FUNERAL DIRECTOR: NAME Williamsen Funeral Home ADDRESS 311 S. Main Fed. md. 21632
25a. DATE REC'D BY REGISTRAR: OCT 26 1987
25b. REGISTRAR'S SIGNATURE:

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Dr Eglsedee. m.e. notified

BP

DHMH - 1650M 1/81 (VRA 15, 4)

067908 OCT 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30005

1. DECEASED NAME (TYPE OR PRINT): First Richard; Middle R.; Last Wright

2a. DATE KNOWN OF DEATH ESTIMATED: X; Month 10-2; Day; Year 87
2b. HOUR DEATH: 20 6 a.m.

3. SEX: M.
4. RACE: Black
5. DATE OF BIRTH: Month Day Year: 5 28 1937
6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS.
IF UNDER 1 YR. MONTHS / DAYS
IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: Month Day Year: 10-2 87
2d. HOUR PRONOUNCED DEAD: 20 6 a.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.
7b. CITIZEN OF WHAT COUNTRY?: U. S.
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD

10. CITY OR TOWN OF DEATH: Easton
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN ANY FACILITY, GIVE STREET ADDRESS): Easton Memorial
12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Laborer
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Talbot
13c. CITY OR TOWN: Easton
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET ADDRESS: Box 558 Easton, Md. 21601

14. FATHER'S NAME: First Clifton; Middle Robert; Last Wright
15. MOTHER'S MAIDEN NAME: First Mary; Middle Edith; Last Wayman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 214-34-8394
17. INFORMANT: Joyce Mathews ADDRESS: Box 107 Oxford Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atherosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE: Ludwig J. Eglseder III M.D. TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER
DATE SIGNED: 10-2-87
EXAMINER'S NAME (TYPE OR PRINT): Ludwig J. Eglseder III, M.D. ADDRESS: Rt.3, Box106, Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10-6-87
23c. NAME OF CEMETERY OR CREMATORY: Spring Grove
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Denton Caroline Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Bernie Smith Box 928 Hurlock Md.
25a. DATE REC'D BY REGISTRAR: OCT 07 1987
25b. REGISTRAR'S SIGNATURE: Peter Davidson-Kindall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP
DHMH - 17 (VR A15 ME (5))